

## **Statement of James R. Bean, MD**

**on**

### **Medicare Complexity and Regulatory Burdens**

Chairman Nussle, and Members of the Committee, thank you very much for inviting me here today to speak to you about problems that physicians face in dealing with the regulatory burdens of Medicare. My name is James R. Bean, and I am a neurosurgeon in private practice from Lexington, Kentucky. As you all might imagine, when I went to medical school I went to learn how to treat and take care of patients. Unfortunately, the time I spend with my patients is dwindling because of the ever-increasing number of rules and regulations issued by Medicare. Today I will share with you some examples of the effect Medicare regulations are having on my medical practice, although they are the same problems that physicians around the entire country are experiencing.

I am one of four neurosurgeons in our practice, which also employs an additional 19 employees to perform all the necessary medical office administrative functions, such as scheduling, transcription, medical record keeping and billing and collections. I see 30-40 patients per day, 2 or 3 days per week, and perform surgery 8-10 hours per day, 2 or 3 days per week. In addition to my regularly scheduled work, I also serve "on-call" to several hospitals, providing care to patients with emergency medical conditions. I have been in practice in Lexington for 21 years, and have been increasingly frustrated with Medicare's regulatory burden. This burden takes several forms in a physician's office, creating unnecessary delays, expenses, and frustrations without perceptible benefit -- either to the patient or the physician. Many of these regulations also expose physicians to potential civil penalties imposed by the Centers for Medicare and Medicaid Services (CMS -- formerly HCFA) and the Office of Inspector General (OIG). Whether any benefit accrues to the

Medicare program, however, is unclear. If it does, it is at the expense of enormous time, money and effort, which would be better used for treating patients and solving their health problems.

### **Medical Documentation**

Evaluation and management (E&M) services are physician office or hospital visits that do not include a procedure, such as surgery. E&M services are categorized according to the AMA's Current Procedural Technology or CPT coding system. Visits are classified according to the location of the service and the type of service performed, such as new office visit, follow-up visit, new hospital consultation, follow-up hospital visit, and so on. Each type of code has 3 to 5 levels of complexity, ranging from simple to highly complex, with the more complex codes paid at higher rates. In my practice, E&M services account for roughly 70% of all the services that I provide.

An E&M service involves a history, a physical examination, and an assessment and plan of action (medical-decision making). Following the visit with the patient, the physician documents this E&M service in the medical record, which is meant to convey the important medical information about the patient, the problem he or she is experiencing, and what course of treatment is required. The sole purpose of the medical record should be to remind the physician and office personnel later of what was found and decided that day, and to communicate this information to other physicians who need to also evaluate and treat the patient.

Beginning in 1995, however, Medicare began to define what particular items had to be included and documented in the medical record in order to qualify for payment at a particular level of service. Because of physician objections to the confusion and complexity of the rules, the requirements were revised in 1997, 1999 and 2000. Each time physicians objected just as strongly to the requirements as being burdensome, confusing and not reflective of the practice of medicine.

Medicare's E&M Documentation Guidelines are most objectionable because they require "bullet counting" of clinical elements necessary to be included in the medical record, whether or not those items have any relevance to the patient's problems. For example, the neurological physical examination section has 21 items. Each level of service has a requirement for notes about an arbitrary number of items, such as 12 items for a middle level (level 3) office evaluation and 6 items for a level 2 evaluation, regardless of whether the information is helpful in understanding the patient and the problems.

In order to make the document fit the level of service and comply with Medicare rules, I have to examine a complex series of grids with each dictation to see if enough information has been included in the medical report. In order to attempt to comply with this system, physician offices have attempted to design standardized templates and reference guides, but these are often just as incomprehensible as the underlying regulations. I've attached a sample template, which illustrates just how complicated this system is.

Medicare's E&M Documentation Guidelines have tried to transform the medical record into a billing and accounting document. The Guidelines do not reflect the actual practice of medicine. They are so complex and inflexible that physicians have to spend extra time adding extra information that is not medically relevant, in order to avoid rejection of the claim or the accusation of fraud. When determining the appropriate level of E&M service, there are no right or wrong answers, but only shades of gray. From a doctor's point of view this is appropriate so we can ensure that the system has enough flexibility so clinical differences can be captured in the medical record appropriately. Unfortunately, these guidelines have attempted to apply a black and white approach, which appeals to the regulators and auditors. The art and science of medicine cannot always be described to satisfy the non-physician auditor, while at the same time satisfying doctors' and patients' medical needs.

I understand that HHS Secretary, Tommy Thompson, has requested that CMS place this project on hold, so we take a step back at reevaluate the kind of documentation system that is necessary. I, personally, would welcome this review and urge the Committee to support this review process so a new more workable system can be developed.

### **Procedure Coding and Billing**

All physician services are identified by a CPT code for purposes of billing Medicare. There are over 8,000 CPT codes describing all the various medical procedures currently in use. For instance, the CPT code 61510 is the code for an operation for a brain tumor. Sometimes a second code is used to describe something done during the same surgery, but not included in the description of the primary code. For instance, sometimes a shunt must be placed when the tumor has blocked spinal fluid drainage in the brain. In that case a second CPT code, 62192, would be submitted as well.

The physician office fills out a Medicare claim form with the patient information, the description of the service, and the charge for the service. The claim is submitted electronically or by mail to the local Medicare insurance carrier, who reviews the claim and returns the payment to the physician office. If all the information on the claim form is correct, the claim is processed; if not, the claim is rejected. The claim can be resubmitted by the physician's office with corrections made to the information, or rejections may be appealed.

Medicare uses computer "edits", or screens to identify codes that should not be submitted together. Some edits are simply wrong, either because of misunderstanding by the agency, or just due to human error. To illustrate how frustrating a wrong error can be, I'll relate to you my experience with a claim for burr hole drainage of a subdural hematoma (blood clot on the brain), where the

local Medicare carrier rejected CPT 61154. The rejection code (CO-97) indicated that the “payment is included in the allowance for the basic service/procedure.” This obscure language means that the service payment is included under another procedure code submitted at the same time, termed the primary procedure. The absurdity is that there was no other code or primary procedure submitted and 61154 **was** the primary code. Since the computer glitch prevents recognition of 61154 as the primary code, it cannot accept the claim and no payment can be made. Our office called the Medicare carrier and was told that this was a “system error” and that the bill could be resubmitted. There was no assurance that the computer error would be eliminated or that the claim would not be rejected again.

Claims payments are rejected for numerous other erroneous reasons. Often Medicare identifies a second payer it believes should be the primary payer, such as auto accident insurance, and the claim is forwarded without notification of the practice. In our practice, we had an instance of Medicare identifying a Workers Compensation carrier claim as the primary payer through the existence of a 30-year unsettled claim. That service was never paid by anyone. Usually there is little recourse. If a rejected claim is appealed to our Medicare carrier, the current delay in resolving the claim in Kentucky is approximately one year.

The time spent by office personnel on resubmitting and appealing claims often costs more than the amount of payment received, even if the resubmission or appeal is successful. For many claims this means it is less expense to the practice to forget the claim than to use personnel time on repeated telephone calls and repeated claim submissions. We have examples of claims resubmitted 8 or more times, with or without final payment. We have examples of claims simply lost by the Medicare carrier or receipt never recorded. When the claim is not acknowledged to have been received within 120 days of service, it becomes ineligible for processing, and payment is never made.

The ever-changing rules for submitting claims are so extensive and labyrinthine that nobody can keep track of them all, or of the changes made each year. There are 6 different categories of laws and regulations that I am expected to know, and each involves hundreds and even thousands of pages.

1. Federal statutes
2. CMS Regulations
3. Medicare Manuals & Program Memos
4. Medicare Carrier & Intermediary Policies
5. Bulletins & LMRPs (Local Medicare Review Policies)
6. Generic Rules (e.g. CPT coding rules)

The rules in levels 2-6 sometimes conflict with each other, so that it becomes literally impossible to remain in compliance with the rules. Certainly a reduction in the number of irrational and conflicting rules is not just reasonable, but urgent. CMS should also standardize the timetable for releasing new rules and regulations (for example on a quarterly basis), so physicians can better keep-up with the requirements of these rules. In addition, CMS has an absolute responsibility in educating physicians about these rules and regulations so they are able to be compliant.

### **Physician Credentialing**

Physicians who apply to participate in the Medicare program must submit an application.

Applications from hospitals for privileges and private insurers for participation are common. The application required by the Medicare program is the lengthiest and most difficult to understand of any that a physician must complete in the course of practice. The application form has 10 pages of instructions explaining how to fill out the form, and 17 pages in the application itself.

The rules of the application are still confusing, despite, or perhaps because of the lengthy instructions. As an example, an application for a physician assistant (PA) who joined our practice in November 1999 took until November 2000 to be approved. The application was returned several times before the problem could be understood and resolved. The problem turned out to be that the PA had different Medicare Personal Identification Number (PIN) assigned to the PA while working several years before at another practice. The carrier was unable to simply inform our practice that a prior PIN number in their records was the source of conflict. We therefore had to fill out a different application form.

This is one area that the Committee should recommend CMS make some changes.

### **EMTALA Regulation**

The Emergency Medical Treatment and Labor Act, or EMTALA, was passed in 1986 in response to reports of patient “dumping”, or transfer from one hospital to another because the patient lacked insurance coverage. While certainly laudable in its purpose, since it was passed, CMS has issued a series of regulations related to EMTALA, which have expanded the scope of the law increasing the burdens on physicians to comply with the complex requirements of these rules. In addition, in some instances, the regulations make it more difficult to provide effective treatment, and rather than protecting patients the rules may actually endanger them.

Lexington has 4 hospitals for which our practice covers emergency call. When I receive a call for an emergency transfer from a hospital *outside* of Lexington while I am performing surgery, the patient is transferred to the hospital at which I am operating. If the patient arrives while I am still in surgery, the patient can be stabilized and evaluated in our emergency department and diagnostic scans are performed, which I can review while I am still in surgery. Once I decide if emergency procedures are necessary, I can make arrangements for treatment, and even prepare that second

patient for emergency surgery, to follow the case I am completing. With the patient at the facility where I am operating, I can make decisions and arrangements that prevent any delays in treatment.

If, on the other hand, I receive a call from one of the other hospitals in Lexington for an emergency patient with a similar problem, and the most efficient treatment would be to have the patient transferred to the hospital at which I am operating, EMTALA regulation defines the transfer in this case as a dumping violation, so treatment decisions are delayed until I can finish the surgery, travel to the other hospital, see the patient, arrange new diagnostic studies if needed, and arrange for emergency treatment, even possibly surgery. This enforced delay could result in additional injury that could have been avoided if the in-city transfer had been permissible.

In addition, I am also potentially liable for not responding to the second hospital, even though I may be at hospital one performing surgery and unable to respond. In order to strictly adhere to EMTALA regulation as written, I would be unable to schedule or perform any surgery during the days I am scheduled for emergency call at any of the 4 hospitals. This would allow me to arrive at any of the 4 hospitals within 30 minutes of being called. It would also reduce my availability for routine surgery by 25%. If I were a solo neurosurgeon in a town with only one neurosurgeon, I could never perform elective surgery without being in violation of EMTALA's availability rule. It is the most inefficient and wasteful way to manage the time and availability issue, ignores common practice that worked prior to the regulation, and creates unnecessary risks both for the patient and the surgeon.

There are other examples of the absurdity of the application of this regulation. One hospital at which I perform surgery commonly utilizes an MRI scanner separated from the hospital grounds by ½ block. Often patients who come to the emergency room at that facility need an MRI scan to decide on proper treatment. Accomplishing the scan requires an ambulance to transfer the patient

the ½ block to obtain the scan and return to the hospital emergency department. That process constitutes a “transfer” under EMTALA regulation and a violation of the rules. In short, the process of obtaining the necessary emergency diagnostic studies requires a violation of EMTALA regulation.

I seriously urge the Committee to explore in detail the complexity and burdens of the EMTALA regulations, and the potential damaging effect that they are having on patients, physicians and hospitals alike.

Thank you for your attention and the opportunity to relate a few of the very real and onerous problems that CMS regulation has created in my daily medical and surgical practice. I look forward to being a resource to the Committee as you evaluate solutions to these and other problems. These examples are, of course, only the tip of the iceberg, and comprehensive change in how CMS operates would likely address most, if not all of these.